DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY
CONTROLLED DRUG WAIVER APPLICATION

PLEASE PRINT OR TYPE

FAX TO: **ATTENTION:**	617-753-8165 **BARBARA ROSS (617-753-8119)**
FROM: **ATTENTION:**	**FACILITY:** _____ **FAX:** _____ **NAME:** _____ **PHONE:** _____

Submit by fax your application for a waiver of 105 CMR 150.008(C)(2)(c) and 153.030(B), to administer a long term care resident a controlled substance not listed in the above regulations. Your application will be reviewed and faxed back to you with the Department's response indicated below.

RESIDENT:	_____
PHYSICIAN:	_____

EXACT PRESCRIPTION NAME:	Dosage (# of mg./tabs): _____ How Administered: _____ Pain/Other: _____ PRN/Other: _____ Refills: _____ # of pills: _____

Reason for Therapy:

Facility Staff Person Requesting this Waiver:

NAME: _____ POSITION: _____

SIGNATURE: _____ DATE: _____

Have staff been in-serviced on the clinical use and adverse effects of the drug(s)?
Yes ____ No _____

If "No": An in-service will be done on _____ by the following physician, nurse, or pharmacist:

_____

FOR DEPARTMENT OF PUBLIC HEALTH RESPONSE ONLY:

APPROVED: _____ DATE: _____

This approval is contingent upon the conditions as follows:
1. Approval is for no more than 90 days.
2. The medication is to be discontinued and appropriately destroyed, if any of the medication remains at the end of the 90 days.
3. Administration of PRN medications for pain should be based on the resident's assessment of need.

DENIED: _____ DATE: _____

PROGRAM MANAGER: _____ DATE: _____

ASSISTANT DIRECTOR: _____ DATE: _____